

STATE OF NEBRASKA

Department of Health and Human Services
Regulation and Licensure
Credentialing Division
PO Box 94986
Lincoln, NE 68509-4986

**APPLICATION FOR APPROVAL OF INITIAL
ASSISTED-LIVING FACILITY ADMINISTRATOR TRAINING**

Name: <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.			
Home Address:	Street/PO/Route:		
	City:	State:	Zip:
Home Telephone Number:		FAX Number (if applicable)	
Facility Name:			
Facility Address: (if applicable)	Street/PO/Route:		
	City:	State:	Zip:
Facility Telephone Number:		FAX Number (if applicable)	
Social Security Number:		Birth Date:	
After January 1, 2005, an Assisted- Living Facility Administrator must have successfully completed initial training consisting of a total of at least 30 hours. (175 NAC 4-006.02A) Verification of initial training completed must be submitted to the Department for approval. Please check one of the following and submit documentation for verification: (175 NAC 4-006.02B)			
1	<input type="checkbox"/>	Evidence of completion of training (certificate or letter) including documentation of date of training, number of hours, description of training, and trainer qualifications;	
2	<input type="checkbox"/>	Evidence of successful completion of college courses and/or degrees which includes topics in 175 NAC 4-006.02A listed below; Resident Care and Services Social Services Financial Management Administration Gerontology Rules, regulations, and standards relating to the operation of an Assisted-Living Facility	
3	<input type="checkbox"/>	Evidence of completion of a Department approved training program; or	
If an Assisted-Living Facility Administrator is currently licensed as a nursing home administrator or is a hospital administrator, the following must be submitted:			
1	<input type="checkbox"/>	Evidence of current licensure as a nursing home administrator in NE or other jurisdiction	
2	<input type="checkbox"/>	Evidence of a statement from the governing authority of hospital or other authorizing entity that can verify administrator status.	

Applicant Signature _____ Date _____

For Department Use

If Applicable -- Date of Request for More Information _____

Information Requested _____

Date additional information received _____ Registry # _____

Approval/Denial Notification Date _____ Date Registered _____

Department Staff signature _____